VSH Futures Advisory Committee
August 7, 2006

Minutes

Next Committee Meeting: September 18, 2:00-4:30 p.m. Skylight Conference Room, State Office Complex, Waterbury

Meeting Participants

AHS Secretary Cindy LaWare, Acting Health Commissioner Sharon Moffatt

Advisory Committee Members: Jill Olson, (for Bea Grause) VAHHS; Linda Corey, VPS; Kitty Gallagher, ASPSC/VPS; Jack McCullough, MH Law Project; David Fassler, MH/SA Professionals Assoc., Peter Tomashow, CVH; Larry Thomson, VSH; JoEllen Swaine, VSH; Peter Albert, Retreat Healthcare; Diane Bogdan, DOC (for Janice Ryan); Stan Baker, DS/HCHS; Michael Sabourin; Larry Lewack, NAMI-VT; Conner Casey, VSEA; Jackie Lemon, HCHS, Paul Dupre, WCMH/VT Council; Anne Jerman, VSH; Sandy Steingard, HCHS.

Guests: Morgan Brown, Rep. Anne Donahue, Counter Point; Rep. Floyd Nease; Maureen Mayo, VCDR; Bruce Spector, BISHCA

Staff: Beth Tanzman, Dawn Philibert, Brian Smith, VDH: Wendy Beinner, AAG

Agenda

1. Introductions
2. Process for disseminating information re: Futures costs
3. Continued work on increasing collaboration & decreasing coercion
4. Certificate of Approval process
5. Work Group updates
6. Project Updates

Secretary Cindy LaWare opened the meeting by introducing Sharon Moffatt. In her capacity as Health Commissioner Sharon will work closely with Beth and Cindy on the Futures Project. Sharon will facilitate the Advisory Committee meetings. Sharon will serve as the Acting Health Commissioner for the foreseeable future.

Paul Blake has announced his retirement effective September 1st. Deputy Health Commissioner Barbara Cimaglio will serve as acting Deputy Commissioner for Mental Health while the MH Deputy position is under recruitment.

Minutes of the June 26th Committee meeting were distributed.

Process for disseminating developing Futures cost estimates

Beth opened the discussion identifying the following considerations. We continue to make good progress on the Futures project. As we begin to understand the preliminary capital and operating cost models, there will be several draft estimates from multiple perspectives developed and considered. In addition, the analyses and estimates will evolve over time as the programmatic operations; site and design plans become more specific and detailed.

We are interested in sharing the information we receive as the project will be best served if developing information is considered. However, for clarity it is important to establish a method to identify financial analysis and/or cost estimates *that reflect the consensus of key parties.*

The Secretary has identified the Chief Fiscal Officer of the Agency of Human Services (AHS) as the single source for operations and construction cost estimates that represent such consensus. Cost estimates released by other groups will be considered preliminary and not fully vetted.

David asked if the Futures Advisory Committee will have the opportunity to review and confirm the cost estimates. Beth stated that any cost estimates released by the AHS Fiscal Office will be shared with the Committee; the Committee may in turn provide input to the AHS Secretary about this and any other aspect of the Futures Project.

David asked if there were cost estimates for the construction of new inpatient facilities at Fletcher Allen Health Care. Beth replied that there are very preliminary cost ranges that were developed by the Department of Buildings and General Services (BGS) via the contract with Architecture Plus. These cost ranges will not be released by the AHS Fiscal Office and do not reflect consensus among the parties. Because BISHCA does require initial cost ranges for the Conceptual Certificate of Need application; BGS will supply their figures for the application.

Conner asked if there were any estimates for the costs of operating a new inpatient service. David followed up asking what operations costs will be used for the CON application. Beth stated that, as per BISHCA's guidance, the actual operating costs of VSH for 2006 will be used.

Beth described the work process that will be used to develop operations cost estimates for a service that could be operated by FAHC. The VSH and FAHC staff will convene a workgroup to develop a "Concept of Program Operations". This group will develop a detailed description of how the service will operate including: staffing, patient care, medical records, housekeeping, pharmacy, materials management, meals etc. Cost models will be developed based on the program of operations.

Larry Thomson stated that private services almost always cost more than public sector and that the per diem rate at VSH covers all costs while that is not true of the per diem rate at private hospitals.

Public Comment was taken:

- The Futures plan approved by the legislature only calls for 32 inpatient beds; the Futures Advisory committee should review whether or not Rutland Regional Medical Center and the Retreat Health Care meet the criteria for secondary programs.
- Don't refer to people as "peers" or anything else unless they self-identify that way.

Continued work on increasing collaboration & decreasing coercion

Beth distributed the revised framework based on the discussion from the last Advisory Committee Meeting. Highlights from the previous discussion included focusing more on increasing collaboration than on reducing coercion and that program type does not directly relate to involuntary legal status.

Language was discussed with Larry Lewack offering that "collaboration" has connotations related to organizations and mergers, he prefers "choice". Other terms suggested include: engagement, empowerment. Linda offered that the concepts of empowerment, choice and the chance to learn from mistakes as better describing the ideas intended. David suggested that one of the categories to describe the voluntary-involuntary spectrum for community programs is whether or not the door is locked. He also suggested that we should differentiate between the types of involuntary emergency interventions that all staff should be trained in and things like seclusion and restraint. There was general assent that staff of residential and crisis bed programs need to have the skills to safely de-escalate emergency situations in which harm to self or others may be imminent. Such approaches may be preferable to calling the police. Larry Lewack pointed out that family members may be reluctant to involve police for fear that they may over-react and would likely prefer staff have skills to maintain safety.

David suggested including another column for hospital voluntary programs stating that "Designated Hospital" means involuntary to him. Sandy offered that she disagrees that expanding unlocked inpatient beds would reduce the need for locked beds. Further clarifications were discussed to cells in the framework that have not been fully resolved. Paul offered that the community residential programs are really designed to be voluntary – in that people need to agree to or want to be there (even if they are on an order of non-hospitalization). As primarily voluntary programs he would not recommend that ACT 114 (non-emergency involuntary medication) orders be *initiated* in community programs. However, if a person wanted to leave the hospital to live @ Second Spring and they are on an order of involuntary medication, he suggests that it may be better to *continue* that order rather than to let a long cycle of going off medication and becoming sick start all over again.

Group members questioned whether any of the community programs listed in the matrix could be differentiated based on the voluntary-involuntary spectrum. Others pointed out that the one exception may the secure residential concept in which the doors probably need to be locked. Finally, participants recommended against attaching Act 114 to any particular program. Jack summarized stating that we should adjust the matrix to reflect whether or not the program doors are locked, that areas which are currently unresolved should be so identified in the matrix, and that the whole concept of the matrix misses the point because it is about coercion and not about how we get to a system that doesn't have coercion. Linda added that it is really hard to come to a consensus about any framework because the issues are so individual. Kitty stated that most interventions should be based on choice and that all clients should have a course on or be supported to evaluate the pros and cons of their situations, whether something was working or not, and to evaluate the costs and benefits of side effects.

Public comment was taken:

- The matrix is a helpful framework for discussion; the concepts may be best captured with "how to increase collaboration and choice to decrease coercion"; the concept of continuing already established orders for medication in community recovery residences could still be consistent with the voluntary nature of the programs (similar to ONHs); the assumption that ACT 114 would be carried out in the specialized and intensive inpatient programs that replace VSH doesn't seem like an expansion of Act 114 but it would definitely be an expansion into more than one setting and given the track record of EEs @ Designated Hospitals (DH) this is a real concern; any discussion of using ACT 114 in the current DH programs is a totally new discussion.
- All there has been is lip service to reducing coercion; the DOJ investigation proves this; now you want to export ACT 114 to the community? Don't open this up.

How do we have the discussion about ACT 114

Beth offered the context that currently the only place Act 114 is used is at VSH. At different times Advisory Committee members have requested that any change to the use of ACT 114, especially as regards the Futures Project, should be discussed.

Larry suggested that the matrix be given to any new program and that each program should report back on how it will increase choice.

Linda emphasized that consumers should participate and be included. Jack suggested that the Futures Advisory group as a whole should discuss the application of Act 114 to the Futures plan "don't farm this out to work groups" and that sufficient time be allowed at the next meeting for a full discussion. Sandy asked, doesn't the Futures committee want to be on record as making a statement about Act 114, especially considering that the VSH may not be here as an entity in the future. David suggested that "we let the issue

sit" as it is too divisive and the Future committee could never get to consensus about it. He offered that he expects Act 114 will be used in those programs that provide intensive and specialized inpatient care but that any expansion beyond these would be very disruptive. Michael said Act 114 should not be expanded out of the current VSH setting. Peter Tomashow observed that to not use Act 114 in the specialized and intensive new inpatient programs would require "radical change in the system".

- David offered the motion: **For the time being discussion on modifications to the use of Act 114 be limited to the new intensive and specialized inpatient programs to replace VSH.**

The motion was seconded by Michael. The voting on the motion was:

In favor:	5
Opposed:	6
Abstained:	6

The motion was not passed.

Kitty stated that she needs more information to talk about the issue.

Sharon summarized the next steps as she understood them:

- The committee will discuss this as a whole (not in work groups)
- The discussion will require time and should be preceded by more information about what Act 114 is and how it is used.
- The discussion must include consumer participation

Certificate of Approval process

Dawn Philibert reviewed the revisions to the Certificate of Approval (COA) process for designated agencies proposing significant capital expenditures (see handout: Revisions to the Draft COA Procedures, August 7, 2006). These revisions were based on input from the public, advisory committee and program standing committee members. Dawn also stated that the public comment period for the Second Spring proposal in Williamstown has been extended through August 9th. Committee members had no additional feedback to give on the revisions to the COA process.

Dawn asked for feedback on the application for the Second Spring proposal in Williamstown. Jack asked to clarify that the applicant is a Designated Agency. The applicant is: Washington County Mental Health, the Howard Center, and the Clara Martin Center. Michael stated that the review and approval should be up to the local board of directors.

Public Comment was taken:

- The state must have a plan to close the beds behind the clients transitioning to Second Spring; and what are the resources for people who leave the Williamstown program?
- Public hearings should be advertised more widely; more time should be given for public comment; the lines of governance should be more clear; there should be a board of directors for the program including consumers, families, local residents, and legislators.

Paul Dupre clarified that the chain of command would be through a local program director, and then to Michael Hartman. A local program advisory committee will be created for the project. Washington County MH will serve as the fiscal intermediary and hold the contract for services with the state. Washington County MH will subcontract with "Collaborative Solutions" a private –not-for- profit comprised of HCHS, CMC, and WCMHS.

Updates

Very brief updates were offered.

Public Comment:

- The new AHS policy on reimbursement cuts off all consumer input into the work groups; the advisory committee is statutorily required to review the status of the VSH Governing Body and the Board of Mental Health
- The housing work group charge is too narrow; the state should stop playing lip service to reducing coercion; don't dare expand Act 114 we are organized now.

Sharon closed the meeting at 4:35 pm.